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ABSTRACT

This paper discusses bulimia among college women, and describes a workshop utilizing structured short-term group treatment for these bulemic women. An overview and definitions of bulimia are given, and research supporting the theory that binge eating is a reaction to excessive dietary restraint is reviewed. Treatment goals and techniques used in the 8-week program, which are drawn from cognitive-behavioral, gestalt, and psychodynamic sources, are described in detail. The program was tested on a group of bulimic female students at Duke University in 1983, and results from this program are briefly reviewed. A bibliography, a treatment summary of the 8-week program, a list of dietary facts, and a Binge Analysis Sheet (used in the treatment program) are included. (BH)

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A Short-Term Structured Group Program for the Treatment of Bulimia

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Paper presented at the 1984 meeting of the American College Personnel Association, April 11, 1984.

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Abstract

This workshop presented a structured short-term group treatment approach for bulimic college women based on the rationale that binge eating is primarily a reaction to excessive dietary restraint. Research supporting this rationale was reviewed and techniques for reducing restraint were described. These techniques, which are drawn from cognitive-behavioral, gestalt, and psychodramatic sources, focus on decreasing the thoughts and beliefs which maintain excessive restraint. In addition, the audience had the opportunity to participate in an exercise used in the treatment program. An outline of an eight week treatment program was distributed.

A Short-term Structured Group Program to the Treatment of Bulimia

Overview

Definitional Issues. A variety of terms have been used to describe this eating disorder (bulimarexia, binge-purge syndrome, compulsive eating), but we use the term "bulimia" and define it in accordance with the DSM III. The primary symptoms of bulimia are: episodic binge eating followed by restrictive dieting or purging; the eating is experienced as abnormal and out of voluntary control; extreme self-hate guilt following a binge and repeated attempts to lose weight. Bulimia also has several psychological features in common with anorexia nervosa including an intense fear of becoming fat, a preoccupation with weight and food, and a distorted body image.

Although the symptoms of bulimia occur in individuals of all weights, we'll be discussing our approach to treating normal weight bulimics. We are lenient in the upward direction of what we consider normal; some of our clients are 15-20 lbs. overweight by conventional standards. Recent research shows that 50% of anorexics regularly binge and often purge as often as once a week or more. Also 50% of the obese patients seeking weight treatment report regular bingeing followed by severe depression. Since most (65%) bulimics are normal weight, and most clients you'll see in a college setting are normal weight, we'll confine our talk to that group.

How We Arrived At Our Approach. When we first got interested in this disorder about three years ago there wasn't nearly as much literature on it as there is now. At that time most of the focus was on the bingeing behavior itself, and the two primary explanations seemed to be

that bulimics were deficient in self-control or that it was symptomatic of other problems (e.g., low self-esteem; unassertive; dependent; lacked sense of personal competence and power). The assumption that bulimics need to increase control is questionable since between binges they typically exercise extreme control over their eating. They are usually perfectionistic, set extremely high standards, and attempt to adhere to unreasonably restrictive diets between binges. Although the chronic dieting in pursuit of thinness and the distorted or negative body image of bulimics has been discussed by theorists and clinicians, Susie Orbach (1978) was one of the first to emphasize the role of dieting in binge eating. A major part of her treatment was helping binge eaters give up dieting and accept their current body weight and shape.

In the past few years there has been a growing body of evidence that dieting may play a critical causal role in the development and maintenance of binge eating. The research consistently finds a significant positive relationship between bingeing and dieting in individuals of all weight classifications and among samples of "normal" dieters as well as individuals with eating disorders. Regardless of weight or sex, the severity of binge eating is strongly correlated with degree of dieting concern.

There is the question of whether a causal relationship is involved. It is reasonable to assume that negative body image leads to or at least supports the initial dieting behavior, but do bulimics diet because they binge or binge because they diet? Obviously it can become self-perpetuating cycle with dieting needed to counteract bingeing, especially if the individual does not purge. However, there is evidence that the dieting precedes the bingeing. Boskind-Lodahl and Sirlin (1977) reported that in every one of the 134 cases they had treated, the first binge followed a period of restrictive dieting. Three other descriptive

studies of bulimics and their eating histories (Abraham & Beumont, 1982; Johnson, Stuckey, Lewis & Schwartz, 1982; Pyle, Mitchell & Eckert, 1981) found the same pattern of initial dieting, which was often successful for a while, but then gradually deteriorated into pattern of dieting and bingeing. There was no evidence of bingeing before dieting. I have seen a few cases where the initial weight loss was not planned. These individuals were satisfied with their weight but spontaneously lost weight (approximately 10 lbs.) following a breakup with boyfriend or because of involvements with school or sports. Once the new low weight was reached, however, they liked it so much they dieted in order to maintain it and bingeing began soon after. Hilde Bruch (1973) describes "fat-thin people", women who were overweight but successfully dieted down to normal weight. Once there, they became intensely preoccupied with food and weight and began to binge on the foods, usually sweets , that they no longer allowed themselves to eat. With bulimic anorexics, the bingeing doesn't appear until approximately one year after rigid dieting (Casper, Eckert, Halmi, Goldberg, & Davis, 1980). Finally there is the study on the effects of starvation that Keyes and his colleagues conducted at close of World War II. Perfectly normal healthy males were fed low calorie diet until they lost 25% of their weight. During the "starvation" phase, an extreme preoccupation with food developed. Following refeeding, subjects began to show a tendency to gorge at meals often to the point of feeling sick. These men had no eating problems prior to the study.

Anecdotal support for the hypothesis that dieting may lead to bingeing comes from bulimics self-reports. The most common preciptiants or triggers of binges are being hungry, craving specific foods, and

eating small amounts of forbidden foods. Although external stressors (interpersonal, academic) and negative emotional states (loneliness, anger, boredom, depression) are also often cited as triggers, research with normal dieters indicates that dieting may serve to increase the likelihood of bingeing in response to emotional upset or stress.

Research On Normal Dieters Or Restrained Eaters. A series of experimental studies with college students have been conducted by Herman and Polivy and their colleagues and the results are presented in Breaking the Diet Habit. (Polivy & Herman, 1983). Basically, these studies used the Restraint Scale to identify those subjects who are continually attempting to lose weight or are concerned about dieting (Restrained Eaters) and those for whom weight and dieting is not a concern (Unrestrained Eaters). Then a number of manipulations were developed to determine which factors would interere with the restraint. These researchers theorized that dieters may be suppressing their weight below the optimum physiological weight or set point and that once restraint was broken down, dieters would engage in "deprivation-motivated eating". Although the concept of a set point is controversial, the studies did find that dieters responded quite differently from nondieters to identical stimuli or situations. Specifically, dieters tended to overeat and even binge during a subsequent taste test with ice cream if they were first made to drink milkshakes or consume other preloads such as pudding, ice cream, or even sandiwches whereas non-dieters eat less following a preload. Also, anxiety, depression, and the belief that they have consumed alcohol were found to induce binge-ing in these "normal" dieters whereas the nondieters in similar conditions decreased their consumption. When restraint was not interfered with by

experimental manipulations (no preload, no anxiety or depression induced), dieters ate significantly less than their nondieting counterparts. These laboratory studies closely parallel clinical binge eating in that the same factors appear to trigger binges for bulimics who are also chronic dieters.

Why Might Dieting Produce Bingeing? We're not sure, but it appears that dieters learn to ignore their physiological cues and rely on self-imposed rules or external guides such as formal diets or what the scales say to control their eating. They avoid fattening foods and establish caloric limits or a set of acceptable foods. As long as there is no disruption of restraint they can continue to successfully restrict their intake. However, minor dieting violations, stress and emotional upset, as well as the classic disinhibitor, alcohol, can lead to a breakdown in restraint. Dieting seems to have a number of effects which make it extremely difficult to maintain the control for very long or under less than ideal conditions. These effects include a) increased preoccupation with food, b) a sense of psychological if not physiological deprivation and resentment at not being able to eat what "normal" people eat. c) reactance, (i.e., when something is taken away it becomes that much more attractive), and d) dichotomous thinking. Foods are classified as "good" dietetic foods or "bad" fattening foods. Likewise, eating behavior is labeled good or bad depending on what and how much was eaten, and days/weeks are good or bad depending on whether the individual adheres to his/her diet. This rigid, all or nothing thinking increases potential for bingeing in response to a minor dieting violation. Once a small amount of forbidden food is eaten, there's a "What the hell, I've blown it now" response. Since

bulimics typically promise to diet even more strictly the next day to make up for the excess intake, a binge becomes the feast before the famine. This new diet, however, only sets the stage for the next binge. Regarding bingeing in response to stress, food serves to nurture or distract the bulimics from the original problem. While we all do this to some degree, for bulimics eating is one of the primary means of making themselves feel better because they don't allow themselves to eat most of the time. If they allowed themselves to eat so-called "forbidden foods" everyday, or at least more of the time, they may not so readily turn to food when they feel a need to take care of themselves.

Implications For Treatment. Therapists need to help bulimics reduce restraint or restrictive dieting on both the cognitive and beahvioral levels. Behaviorally this means increasing the types and amount of allowable foods. The client is encouraged to give up rigid dieting and gradually increase her intake to a level reasonable for her age and activity level. Naturally it is difficult to get bulimics who already think they are too fat to quit dieting, thus the beliefs supporting the dieting behavior need to be examined, challenged, and modified. The treatment we will describe now places a great deal of emphasis on helping bulimics develop a more positive body image and accept a body weight or shape that they are able to maintain comfortably without frequent dieting.

Treatment Approach

I'll be talking about the actual treatment that we do. As Suzanne has explained, we were primarily influenced by the restraint literature and the anti-dieting aspects of Susie Orbachs approach. In developing the specific techniques we drew on our background in CBT as well as my training in Gestalt Therapy and psychodrama.

I will first describe the general format, mention some difficulties that arise with this type of group, and describe the screening process and specific techniques we use to help clients meet specific goals. We will then demonstrate one of the exercises and I will present evaluation data that was gathered on a group I did fall semester of 1983 at Duke University.

Beginning with the general format, we meet for eight weeks for 1 1/2 hours. We have had groups ranging in size from 6 to 10 members. We have also done the group with and without co-leaders. We did the group twice together and each did one alone. I would definitely recommend a co-leader if you have one available.

This brings us to one of the main difficulties in doing this type of group. And that is that the clients come to the group with the idea that improvement depends on increasing self control so they can successfully stay on a diet while the therapists have the goal of reducing control and stopping the dieting behavior all together. So in addition to the usually facilitative and educational functions of leaders of structured groups, we are also attempting to produce a great deal of attitude change, actually a change in values, in a short period of time. To do this we must maintain a very delicate balance of challenging some of the bulimics most cherished beliefs while still maintaining enough rapport to be successful influence agents. It really helps to have two leaders who agree as this increases the amount of influence as well as reducing wear and tear on the leaders.

A similar problem occurs with regard to the interactions that group members have with each other. We want enough free interaction and sharing so that cohesion will develop while preventing them from giving each other reinforcement for dieting. Since bulimics attitudes toward eating and weight are so similar, they will quickly develop group consensus that thinness is extremely important and control must be maintained. These ideas are much harder to challenge once the group has come to an agreement regarding them and it is important to interrupt the sort of discussion which seems to be leading in that direction.

I would now like to move to the screening process. The most important characteristic we screen for is the presence of bulimia. That is, we want to make sure they do engage in eating binges in which they consume truly excessive amounts of food, do so in a very frantic way that is experienced as a loss of control, and that the binging is followed by depression. We often ask them to describe a recent binge. We also make sure they have a history of dieting and are still attempting to diet when not binging. We check to see if they are purging and, if so, require a physical exam. We rule out clients with significant psychopathology such as psychotic manifestations and active suicidal ideation. We also rule out people with a simple problem of overweight who just eat large meals or snack a lot. Those people often come to this type of group hoping we will cure them of their fondness of food and help them lose weight. If included, they are likely to be disappointed. We also make sure they are of relatively normal weight.

Also in the screening interview we explain that they shouldn't expect to lose any weight and may actually gain a few pounds. They usually agree that this is fine; they are ready to do anything to get rid of the binge

problem. However, it usually emerges later that they actually believed that stopping binging will help them to lose weight. Quite a bit of frustration usually emerges as the members begin to understand the diet-binge connection and to realize that stopping binging may require that they give up their dreams of perfect thinness.

I want to move now to the goals we attempt to reach with bulimic clients and the specific techniques we use to reach these goals.

I. Our first goal is to reduce the shame, guilt, and secretiveness that usually surrounds the binging behavior and help them develop a support system within the group of people who know about their problem.

1. We begin the group with having people pair up and get to know each other and then introduces their partner to the group. At this point there's generally no mention of the bulimia.
2. The leaders then give a short talk about bulimia emphasizing three main points:
   a. Bulimics usually feel very bad about having the problem and feel like they are the only one who do.
   b. Bulimia is actually a common problem among female college students; it affects from 10%-30% according to various studies.
   c. Bulimia is primarily a reaction to the excessive cultural pressures to be thin and does not mean that the individual is psychologically sick.
3. A third method we use to encourage the group to begin sharing

what they consider the "disgusting" details of their problem is an adaptation of the secrets game. We have them write the details of their "most awful binge" or other binge related behavior they are ashamed of on 3 x 5 cards and have each person pick a card from the pile and read it. As members hear about others behavior as "bad" as their own, they begin to share experiences and feelings which they have never discussed before

4. A fourth technique we use is putting the binging in perspective among other possible sins. After there has been some sharing of feelings of being disgusting and hating themselves, I usually remark that I feel like I'm listening to a group of murders or child molesters while all they have actually done is eat too much.

II. The second goal we have is to reduce the dieting behavior.

1. The first method we use is education regarding the connection between dieting and binge eating. We inform them of the research which Suzanne has just discussed here and also of the set point theory which strongly suggests that the body will fight to maintain a certain weight range for each individual - one that may not be fashionably thin for some. Suggest they read the Dieters Dilemma.
2. We alsc have them examine their own diet/binge histories to establish for themselves that binging usually follows attempts to diet.

3. A third technique is to encourage them to eat a wider variety of foods and more food as an experiment to see what effect this has on binge eating.
4. We also explain that normal people eat according to physiological cues of hanger and satiety as they di d before beginning to diet. We suggest they begin to try and be aware of their physiological cues and eat whenever hungry as well as eating enough to satisfy hunger. We suggest they begin to let their bodies tell them when they have had enough instead of deciding this according to calorie counts.
5. Another technique we borrowed from the book Fat Attack is to have them estimate the amount of money spent on diet books, pills, foods, and clubs/treatments during the past 5 years. We then ask if they are any thinner now than when they began and we ask what else they could have done with that money.
6. We also have two handouts which we will now distribute. The first of these called "what dieting does" is used to produce discussion of the negative effects of dieting and to take advantage of the student mind set of "if I read it, it must be true". The second is a "binge analysis sheet" which I developed in response to students insistence that they binge in response to unpleasant emotions and situations. As you can see I added some questions not usually found on this type of sheet - especially "when did you start" and "what did you do before". In going over this handout in the

group I emphasize that they had the same negative emotions and dealt with them in other ways before they began to diet. I explain that the dieting sets the stage for binging under stress since they now need a "good excuse" to eat favorite foods.

III. I'll move now to the third goal which is to help them accept their present body size and to develop self esteem that is not dependent on weight.

1. The first technique we use is to discuss the effects of the media in promoting an unrealistic ideal of thinness. Students relate well to this topic and we reinforce them for being critical of the present social standards of beauty. We also discuss the recency of this standard.
2. We also use a drawing exercise from Susie Orbachs book "Fat is a Feminist Issue". The clients are asked to draw a picture of their fat and thin selves and to surround each picture with adjectives which describe them while in that state. We question and challenge all nonphysical qualities which they claim only when thin (e.g. intelligent, friendly, successful, sense of humor, loving, etc.) in an attempt to disengage the global self concept from weight. We also ask how many pounds separate their fat self from thin self to highlight the arbitary nature of the distinction.
3. Another technique we have used is to have the group

members each role play one of their significant others. In doing this, they gain another perspective on the importance of weight and usually realize that its much more important to them than to those they care about.

4. We also discuss the pattern of waiting until thin to buy clothes or participate in enjoyable activities. We encourage them to buy clothes that fit now and to allow themselves the experiences they see as exclusively for thin people. We emphasize that much of the misery of being a few pounds over ideal weight is not the objective consequences but the restrictions they put on themselves.
5. Sometimes I will ask each person to look around the group and see if anyone else is at what they consider an ideal weight; without naming the person, I ask if they found anyone. This helps them to see that even people at what they consider ideal weight still feel fat.

IV. The fourth goal we have is to challenge their perception of the binge eating as involuntary and help them to regain a sense of free choice about what to eat. I assume that the subjective sense of involuntary eating is also a result of dieting. As eating becomes labeled unacceptable, the person begins to deny responsibility for overeating and with time truely experiences it as out of her control.

1. One way to help regain a sense of responsibility for eating is to make it acceptable. We constantly reinforce the idea that eating is meant to be pleasurable activity and reinforce clients for eating formally forbidden foods.

2. Second, we conduct a cognitive assessment of a typical binge for one or more members with the focus on decision points. We encourage language change from "I started eating and couldn't stop" to "I decided to continue eating". We identify "excuse making" cognitions and emphasize that they are not necessary.
3. We also challenge the assertion that binges are not enjoyable by asking why they choose to binge on favorite foods.
4. We encourage open rebellion against societal norms for thinness and pressure from significant others to keep them dieting. This helps them choose not to diet rather than be "unable to diet". It is the old gestalt idea of changing can't to won't.
5. We present a gestalt model with the top dog attempting to keep them on a diet through criticism and control while the underdog uses excuses and promises to get food. The main focus is to emphasize the top dogs inability to maintain control and to help them reown the underdogs sneaky eating as their own behavior. To accomplish this we use the traditional empty chair dialog between parts of the self as well as a dyad exercise which we will demonstrate.

In this exercise we ask people to pair up and choose one person to be A and another to be B. We then tell them that each dyad is actually one person who is walking past an ice cream store. Part A wants to stay on the diet while part B wants an ice cream cone. They are to argue about this until time is called; neither is to compromise or give in.

We will now demonstrate this exercise. Suzanne will be part A who wants to maintain control and I will be part B. The statements we are using have been taken from actual bulimic clients doing this exercise.

Before we stop I would like to quickly present some data I collected from a group last semester. I used two pencil and paper objective instruments. The first is the eating disorders inventory which was developed by Garner and associates to measure both the behavior and psychological correlates of anorexia and bulimia. The second instrument is the binge scale which was developed by Hawkins and Clement to measure the severity of binge eating.

I gave both of these instruments before and after the eight week group and found the total score on both decreased significantly ($p < .01$). I also found that three of the EDI subscales usually elevated in Bulimics (Drive for Thinness, Body Dissatisfaction, and Bulimia). I also found a decrease on the Introceptive Awareness subscale at the .05 level.

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Treatment Summary

The group met on a weekly basis for eight 1½ hour sessions. Throughout the eight week sessions, three major themes were repeatedly presented and reinforced: 1) binge eating is a reaction against the psychological and physiological deprivation brought about by dieting; 2) the subjective experience of eating involuntarily is brought about by denying responsibility for choosing to overeat; and 3) it is possible to renounce the ideal of thinness and freely choose to eat an adequate amount of food. The treatment sought to reduce restrictive dieting behavior and to increase self-acceptance of current body weight and shape.

Session 1. The leader provided information about bulimia (manifestations, prevalence, and possible medical complications) for the purpose of reducing members' sense of isolation and shame. Primary emphasis was placed on becoming acquainted with other group members and discussing painful feelings associated with binge eating (embarrassment, self-hate, loss of control, feeling fat, etc.) An adaptation of the "Secrets" game was used to reduce shame and increase openness regarding the extent of overeating. The members were asked to write the details of their most "awful" binge on 3X5 cards and place them in the center of the circle. Each person then chose a card at random and read it as if it were her own. The reading of each card led to further disclosures by other group members. The leader gave a short talk about set point theory and the relationship between dieting and binge eating. She also repeated the point made in screening that the group goal was not weight loss but regaining a feeling of choice about eating. Members were encouraged to gradually increase the variety of foods they allowed themselves to eat and to observe the effects of this "experiment" on their binging and/or preoccupation with food.

Session 2. The leader presented a model drawn from Gestalt Therapy in which a part A (top dog) tries to enforce dieting while a part B (underdog) rebelliously overeats. A role play exercise was used to help participants identify these parts of their own personalities. After the exercise, the leader asked for characteristic statements made by each part and wrote these on the board. She then pointed out that the members consciously identified

themselves primarily with part A while their behavior appeared to be more an expression of part B. After the members discussed this apparent paradox, the leader suggested that part B represented a healthy aspect of the personality which could not be destroyed and which actually grows stronger when opposed. The exercise enabled members to understand that, contrary to their self-perceptions, their problem may be one of too much control rather than too little.

Session 3. The group continued discussion of the self control struggle. Clients were encouraged to share their dieting/binging histories and to examine the relationship between the two activities. Most were surprised to realize that their worst binges did occur after periods of dieting. A handout titled "What dieting does" was distributed and discussed. This session was also used to allow members to ventilate their feelings about the ideas being presented. Since information regarding the diet-binge connection clearly threatens the bulimics dream of staying on a perfect diet, considerable frustration can be expected during the early group sessions.

Session 4. Individual empty chair work was introduced with each member engaging in a dialogue between their "part A" and "part B". The therapist encouraged "part B" in rebellious statements such as "I have a right to eat" as a means of increasing client responsibility for choosing to eat. When appropriate, the therapist asked if the rebellious statement should be addressed to some other person. When the answer was affirmative, the significant other's contribution to the eating problem was explored.

Session 5. A handout was developed in response to students insistence that they ate in response to negative feelings. This handout looked deceptively like the usual "What's bothering you, what did you eat" chart but included two additional items: 1) When did you begin to binge in response to these feelings? and 2) How did you respond to these feelings before you began binge eating? Members completed and discussed the form while the leader pointed out that negative feelings had always been part of their lives and they had responded to them without binge eating before the dieting began.

It was suggested that they now used emotional upsets as an excuse to eat the food they generally denied themselves. The leader presented a brief synopsis of the restrained eating research to emphasize the point that dieting increases the likelihood of binging in response to stress and negative emotional states.

Session 6. A drawing exercise from Fat is a Feminist Issue (Orbach, 1973) was used to increase awareness of the tendency to base self-worth on weight or body size. Each woman drew a picture of herself as fat and thin and listed nonphysical characteristics she attributes to herself in each state. The drawings and lists were shared with the group while the leader encouraged them to question why qualities such as intelligence and sense of humor should be associated with weight. Each member was also asked to specify the number of pounds which separated "fat me" from "thin me" in order to highlight the arbitrary nature of the fat-thin dichotomy.

Session 7. Members discussed progress to date and anticipated problems which might occur during the upcoming Thanksgiving vacation. The most common problem expected was being criticized by some family member or friend for eating too much or having gained weight. Assertive responses such as "I've decided not to lose weight" or "I can control my own eating" were practiced.

Session 8. The group discussed food related problems which had occurred over vacation. As expected, family members comments regarding their weight and food intake were prevalent. Members connected this pressure with rebellious overeating and concluded that they could choose to eat or not eat without their families or friends being involved in the decision. Since this was the last session, members were encouraged to talk about what the group had meant to them and to express sadness about the group ending.

WHAT DIETING DOES

1. May take weight below set point leading to increased physical hunger.

2. Decreases reliance on normal hunger/satiety mechanisms; dieters forget that body can tell them what and how much to eat.

3. Reward value of food increases, especially high calorie foods which dieters avoid; "forbidden fruit" effect.

4. Food related thoughts increase due to planning and monitoring food intake.

5. Good/bad thinking leads to abstinence violation effect ("I've ruined my diet for today so I may as well eat all I want").

6. Planning food intake weeks or months in advance leads to feelings of being restricted and rebellion against restrictions.

7. Attempting to control future intake creates anxiety because future cannot be known or controlled.

8. Repeated experiences of dieting and regaining weight erodes self-confidence and promotes self-criticism.

9. To motivate oneself to stay on the diet, rewards for losing weight are focused on and exaggerated. This leads to unrealistic assessment of the importance of weight.

10. Pleasing others is often used for motivation also, even if others have not expressed interest in having one lose weight. This leads to the assumption that others will be disappointed or rejecting if the diet is broken and thereby decreases security in relationships.

11. Encourages eating in response to emotional upsets since a good excuse is needed for eating forbidden foods ("I meant to stay on my diet but I was too upset.")

Binge Analysis Sheet

	Emotion	Situation
List an emotion and a stressful situation you often respond to by overeating.		
How does eating help you deal with this emotion or situation?		
Have you always overeaten in response to this situation or emotion?		
If not, when did you start?		
How did you deal with this emotion or situation before you began to binge?		

Do you always overeat in response to this situation or emotion now?		
If not, what do you do at other times?		
How do you decide when to respond by eating?		